

# Benefit Options

**Choice. Value. Health.**

## TRANSITION OF CARE FORM

Please note that this information pertains to you and/or your dependents health care and is not intended for authorization of services.

If you are currently under the care of a non-network provider, there are a limited number of medical conditions that may qualify for Transition of Care. If transitional care is appropriate, specific treatment by a non-network provider may be covered at the network level of benefits for a limited period of time. These services are subject to eligibility and coverage limitations at the time the medical care is administered.

**This form must be submitted within 30 days of your new enrollment date.**

☐ Please check box if this is dependent information.

Employee Name:		DOB:	Employee ID#:
Dependent Name:		DOB:	<b>EPO</b> <input type="checkbox"/> RAN+AMN <input type="checkbox"/> United HealthCare <b>PPO</b> <input type="checkbox"/> AZ Foundation <input type="checkbox"/> Beech Street <input type="checkbox"/> United HealthCare <b>Medicare Primary</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Day Time Phone: (    )			
Address:			
Primary Care Physician:			Phone: (    )
Do you use any specialty injectable medication other than insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:			
Are you presently scheduled for/or recently receiving any of the following services? Check all that apply.			
<input type="checkbox"/> Elective Surgery (Including transplant)	Facility: Nature of Surgery:	Date:	Physician Name: Phone:
<input type="checkbox"/> Pregnancy	Due Date:		Physician Name: Phone:
<input type="checkbox"/> Radiation Oncology	Facility:	Date:	Physician Name: Phone:
<input type="checkbox"/> Chemotherapy	Facility:	Date:	Physician Name: Phone:
<input type="checkbox"/> Dialysis	Facility:	Date:	Physician Name: Phone:
<input type="checkbox"/> Outpatient Rehabilitation	Facility:	Date:	Physician Name: Phone:
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Cardiac Therapy
<input type="checkbox"/> Home Health Services	Agency Name:	(Including skilled nursing)	Nature of Services:
<input type="checkbox"/> Durable Medical Equipment	Vendor Name: Please check all that apply: <input type="checkbox"/> Catheter supplies <input type="checkbox"/> CPAP <input type="checkbox"/> Bed/Mattress <input type="checkbox"/> Other: <input type="checkbox"/> Ostomy supplies <input type="checkbox"/> Oxygen <input type="checkbox"/> Wheelchair <input type="checkbox"/> Diabetic Supplies		
Do you have any of the following diseases: <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> CHF			
Do you have any health care concerns where you may need assistance from a case manager? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain:			
Are you currently receiving mental health services: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide the following:	
Provider Name:		Provider Phone: (    )	Date of Next Appt:
Are you currently receiving substance abuse services: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide the following:	
Provider Name:		Provider Phone: (    )	Date of Next Appt:

**Please fax this form to your designated claim carrier:**

AFMC RAN+AMN Beech Street:  
Strategic Health Development Corporation  
Transition of Care  
9501 N.E. 2<sup>nd</sup> Avenue  
Miami Shores, Florida 33138  
Fax: (305) 756-1035

UHC:  
United Healthcare  
Transition of Care  
PO Box 30555  
Salt Lake City, UT 84130-0555  
Fax: (801) 567-5499

**Confidentiality Notice:** This document contains confidential information intended for a specific purpose and is protected by law.